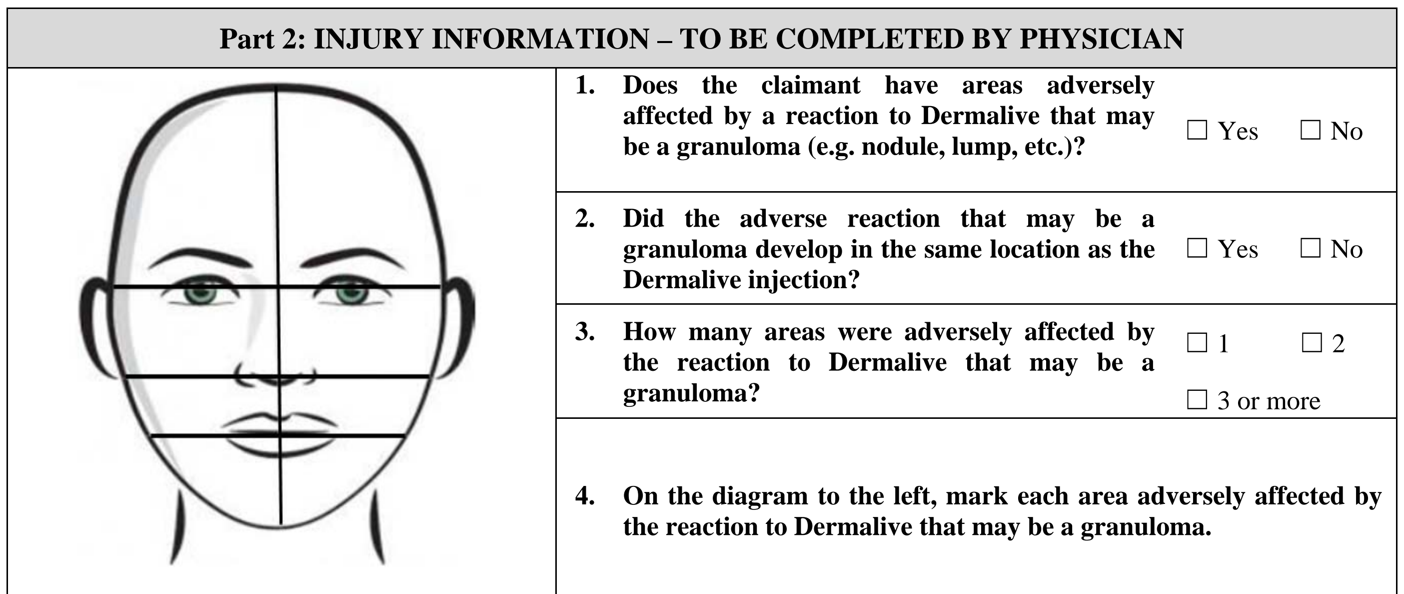
**DERMALIVE CLASS ACTION SETTLEMENT**

**PHYSICIAN FORM**

**Strictly Private and Confidential**

- This form must be completed and signed by the physician of the claimant submitting a **physical injury claim** for compensation under the Dermalive class action settlement.

| **Part 1: GENERAL INFORMATION – TO BE COMPLETED BY PHYSICIAN** | |
|---|---|
| **Print physician's full name** | ________ Last Name ________ First Name ________ Middle Name |
| **Physician's contact information** | ________ Street Address ________ City ________ Province<br>________ Postal Code ( ) ________ Telephone |
| **Physician's specialty or area of practice** | ________ |
| **Print claimant's full name** | ________ Last Name ________ First Name ________ Middle Name |
| **Claimant's contact information** | ________ Street Address ________ City ________ Province<br>________ Postal Code ( ) ________ Telephone |
| **Claimant's date of birth** | ___ / ___ / ____<br>DD MM YYYY |



| **Part 2: INJURY INFORMATION – TO BE COMPLETED BY PHYSICIAN** | | |
|---|---|---|
| | **1. Does the claimant have areas adversely affected by a reaction to Dermalive that may be a granuloma (e.g. nodule, lump, etc.)?** | ☐ Yes ☐ No |
| | **2. Did the adverse reaction that may be a granuloma develop in the same location as the Dermalive injection?** | ☐ Yes ☐ No |
| | **3. How many areas were adversely affected by the reaction to Dermalive that may be a granuloma?** | ☐ 1 ☐ 2 ☐ 3 or more |
| | **4. On the diagram to the left, mark each area adversely affected by the reaction to Dermalive that may be a granuloma.** | |

5. **Answer the following for each of the <u>three most serious</u> adverse reactions to Dermalive that may be a granuloma:**

a) **FIRST AREA adversely affected**

| | | | | | |
|---|---|---|---|---|---|
| **Length =** | _______ cm(s) | **Colour Change** | ☐ *Yes* ☐ *No* | **Tender** | ☐ *Yes* ☐ *No* |
| **Width =** | _______ cm(s) | **Palpable** | ☐ *Yes* ☐ *No* | **Visible** | ☐ *Yes* ☐ *No* |

b) **SECOND AREA adversely affected**

| | | | | | |
|---|---|---|---|---|---|
| **Length** = | _______ cm(s) | **Colour Change** | ☐ *Yes* ☐ *No* | **Tender** | ☐ *Yes* ☐ *No* |
| **Width** = | _______ cm(s) | **Palpable** | ☐ *Yes* ☐ *No* | **Visible** | ☐ *Yes* ☐ *No* |

c) **THIRD AREA adversely affected**

| | | | | | |
|---|---|---|---|---|---|
| **Length** = | _______ cm(s) | **Colour Change** | ☐ *Yes* ☐ *No* | **Tender** | ☐ *Yes* ☐ *No* |
| **Width** = | _______ cm(s) | **Palpable** | ☐ *Yes* ☐ *No* | **Visible** | ☐ *Yes* ☐ *No* |

6. **Has the adverse reaction resolved?** ☐ *Yes* ☐ *No*

7. **Has there been any impairment of function as a result of the adverse reaction to Dermalive? (**Examples: eating, drinking, speaking, smiling, kissing, etc.) ☐ *Yes* ☐ *No*

**I certify that the information provided is true and correct to the best of my knowledge, information and belief.**

________________________________ ________________________

**Physician's Signature** **Date Signed**